Membership Application

Autism Society of North Central Indiana

Name_____

Address_____

City_____State_____Zip _____

Phone (H)_____(W)_____

E-mail_____

Please check the category, which best describes you:

Parent_____ Individual with Autism _____ Family Member _____

Educator _____ Service Provider _____ Medical Professional _____

Membership Fees

Parents and Individuals	free	Family Members	10.00
Educators	10.00	Service Provider	10.00
Medical Professional	10.00	Donation	_____

We are also in the process of compiling a directory. This will make it easier for us to stay in contact with each other. Please indicate if you would like to have your name, address, phone, and e-mail included in the directory:

_____ Yes, please include all my information in the directory

_____ No, please do not include me in the directory.

Please mail completed form to ASNCI P.O. Box 1537 La Porte, In 46352.